

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001203

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 187 Registrar's No. 187

FILED FEB 5 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Greene	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RURAL 1ST ROBBERSON	a. STATE Missouri	COUNTY Greene
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Willard RFD#2		d. STREET ADDRESS Willard RFD#2	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) FRANK MALENOWSKY		4. DATE OF DEATH Month January Day 31 , Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 22 Nov. 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (last birthday) 92
13a. FATHER'S NAME Unknown Malenowsky		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT (Daughter) Mrs. Charles Berry RFD#2 Willard, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Springfield, Missouri
21. I attended the deceased from 1961 to 1/31/62 and last saw him alive on 1-15-62 Death occurred at 4:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE W. H. Zell (Degree or title) 22b. ADDRESS McDaniel Building Springfield, Missouri 22c. DATE SIGNED 2-1-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-3-62	23c. NAME OF CEMETERY OR CREMATORY Robberson Prairie	23d. LOCATION (City, town, or county) (State) Greene County, Missouri
24. FUNERAL DIRECTOR Klingner Mortuary ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 2-2-62 26. REGISTRAR'S SIGNATURE Effie S. Melton	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John Klugner Jr

Licensed Embalmer No. 5102

P. O. Address

Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.